TAOP TRICARE Advanced Course 2010

Claims

Claims Objectives

- Assisting Beneficiaries
- Assisting Providers
- Timely Filing Waivers
- Appeals

Claims

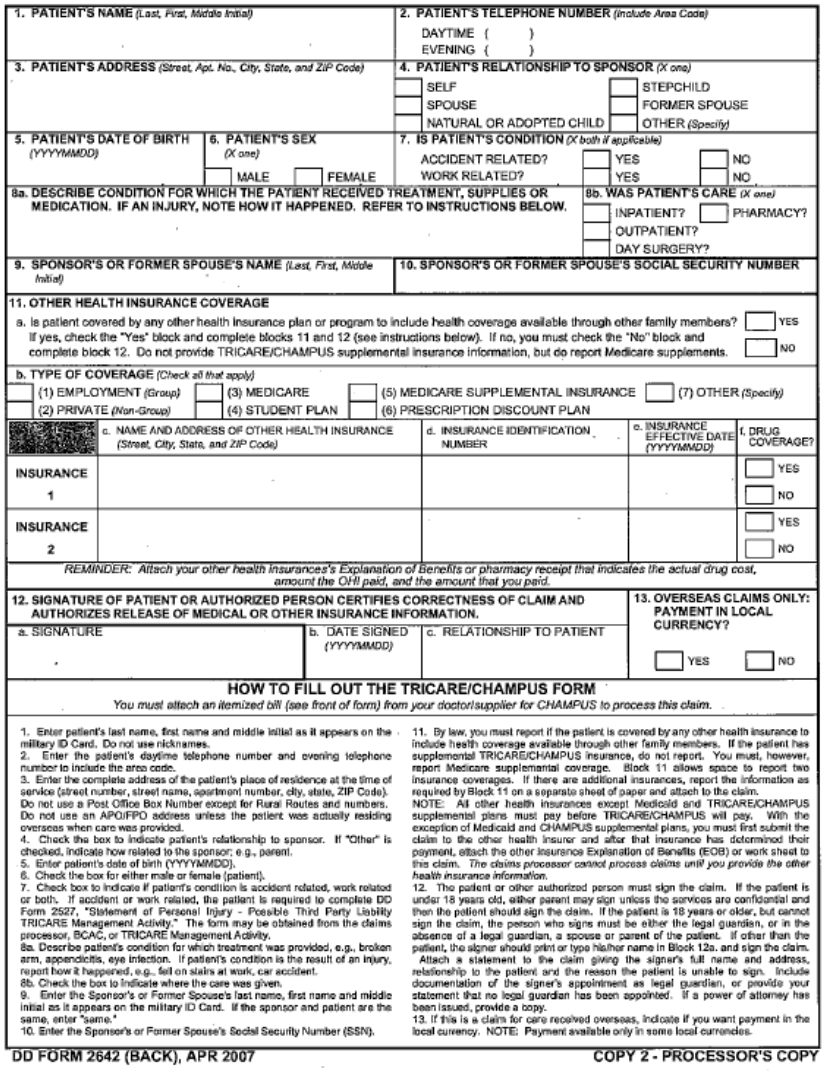
Assisting Beneficiaries

If it happens…

Claims
Assisting Beneficiaries

- DD Form 2642 'Patient's Request for Medical Reimbursement'
  - http://tricare.mil/mybenefit/Download/Forms/dd2642.pdf
- Required Supporting Documentation:
  - Itemized invoice, statement or bill from the provider
  - Receipts showing any payments made by the beneficiary
  - Script from provider when claiming medications
- Timely Filing Limit
  - Within 1 year from DOS or date of discharge from a hospital
  - Independently billed professional fees – 1 year from DOS

Claims
Assisting Beneficiaries



1. PATIENT'S NAME (Last, First, Middle Initial)

2. PATIENT'S TELEPHONE NUMBER (Include Area Code)
DAYTIME ( )
EVENING ( )

3. PATIENT'S ADDRESS (Street, Apt. No., City, State, and ZIP Code)

4. PATIENT'S RELATIONSHIP TO SPONSOR (X one)
☐ SELF ☐ STEPCHILD
☐ SPOUSE ☐ FORMER SPOUSE
☐ NATURAL OR ADOPTED CHILD ☐ OTHER (Specify)

5. PATIENT'S DATE OF BIRTH (YYYYMMDD)

6. PATIENT'S SEX (X one)
☐ MALE ☐ FEMALE

7. IS PATIENT'S CONDITION (X both if applicable)
ACCIDENT RELATED? ☐ YES ☐ NO
WORK RELATED? ☐ YES ☐ NO

8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW.

8b. WAS PATIENT'S CARE (X one)
☐ INPATIENT? ☐ PHARMACY?
☐ OUTPATIENT?
☐ DAY SURGERY?

9. SPONSOR'S OR FORMER SPOUSE'S NAME (Last, First, Middle Initial)

10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER

11. OTHER HEALTH INSURANCE COVERAGE

a. Is patient covered by any other health insurance plan or program to include health coverage available through other family members? ☐ YES
If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "No" block and complete block 12. Do not provide TRICARE/CHAMPUS supplemental insurance information, but do report Medicare supplements. ☐ NO

b. TYPE OF COVERAGE (Check all that apply)
☐ (1) EMPLOYMENT (Group) ☐ (3) MEDICARE ☐ (5) MEDICARE SUPPLEMENTAL INSURANCE ☐ (7) OTHER (Specify)
☐ (2) PRIVATE (Non-Group) ☐ (4) STUDENT PLAN ☐ (6) PRESCRIPTION DISCOUNT PLAN

	c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE (Street, City, State, and ZIP Code)	d. INSURANCE IDENTIFICATION NUMBER	e. INSURANCE EFFECTIVE DATE (YYYYMMDD)	f. DRUG COVERAGE?
INSURANCE 1				☐ YES ☐ NO
INSURANCE 2				☐ YES ☐ NO

REMINDER: Attach your other health insurance's Explanation of Benefits or pharmacy receipt that indicates the actual drug cost, amount the OHI paid, and the amount that you paid.

12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.

a. SIGNATURE

b. DATE SIGNED (YYYYMMDD)

c. RELATIONSHIP TO PATIENT

13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?
☐ YES ☐ NO

HOW TO FILL OUT THE TRICARE/CHAMPUS FORM

You must attach an itemized bill (see front of form) from your doctor/supplier for CHAMPUS to process this claim.

1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.
2. Enter the patient's daytime telephone number and evening telephone number to include the area code.
3. Enter the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state, ZIP Code). Do not use a Post Office Box Number except for Rural Routes and numbers. Do not use an APO/FPO address unless the patient was actually residing overseas when care was provided.
4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., parent.
5. Enter patient's date of birth (YYYYMMDD).
6. Check the box for either male or female (patient).
7. Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity." The form may be obtained from the claims processor, BCAC, or TRICARE Management Activity.
8a. Describe patient's condition for which treatment was provided, e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened, e.g., fell on stairs at work, car accident.
8b. Check the box to indicate where the care was given.
9. Enter the Sponsor's or Former Spouse's last name, first name and middle initial as it appears on the military ID Card. If the sponsor and patient are the same, enter "same."
10. Enter the Sponsor's or Former Spouse's Social Security Number (SSN).
11. By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental TRICARE/CHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Block 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim.
NOTE: All other health insurances except Medicaid and TRICARE/CHAMPUS supplemental plans must pay before TRICARE/CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to this claim. *The claims processor cannot process claims until you provide the other health insurance information.*
12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Block 12a. and sign the claim.
Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.
13. If this is a claim for care received overseas, indicate if you want payment in the local currency. NOTE: Payment available only in some local currencies.

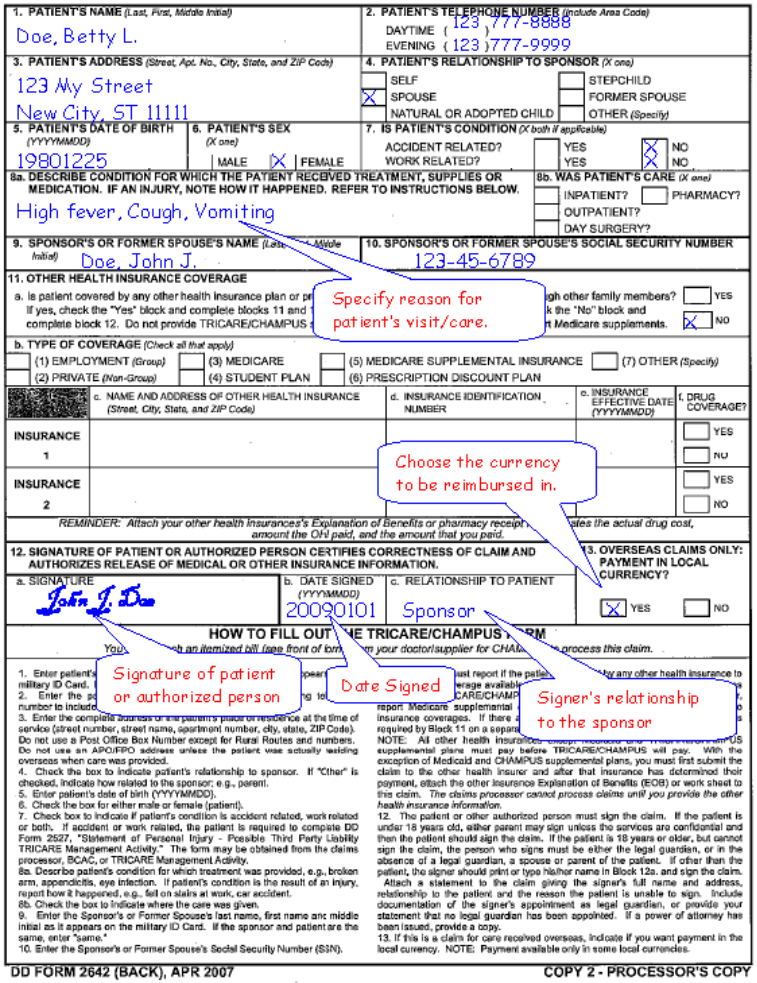
DD FORM 2642 (BACK), APR 2007 COPY 2 - PROCESSOR'S COPY

Claims
Assisting Beneficiaries

DD Form 2642 – Key Points

- (7) If the answer is yes to either of these questions, have the beneficiary complete a Third Party Liability (DD Form 2527) form and submit it along with their claim.
  - https://www.tricare4u.com/apps-portal/tricareapps-app/static/pdf/dd2527.pdf
- (8a) Make sure that the beneficiary has annotated the reason for receiving the medical care.
- (12a.) Verify that the beneficiary/authorized person has applied their handwritten signature. Signatures cannot be typed.
- (13) Verify that the beneficiary has annotated whether they want to be reimbursed in the local currency or in US dollars

Claims
Assisting Beneficiaries



1. PATIENT'S NAME (Last, First, Middle Initial): Doe, Betty L.
2. PATIENT'S TELEPHONE NUMBER (Include Area Code): DAYTIME (123)777-8888; EVENING (123)777-9999
3. PATIENT'S ADDRESS (Street, Apt. No., City, State, and ZIP Code): 123 My Street, New City, ST 11111
4. PATIENT'S RELATIONSHIP TO SPONSOR (X one): [X] SPOUSE
5. PATIENT'S DATE OF BIRTH (YYYYMMDD): 19801225
6. PATIENT'S SEX (X one): [X] FEMALE
7. IS PATIENT'S CONDITION (X both if applicable): ACCIDENT RELATED? [X] NO; WORK RELATED? [X] NO
8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW: High fever, Cough, Vomiting
8b. WAS PATIENT'S CARE (X one)
9. SPONSOR'S OR FORMER SPOUSE'S NAME (Last, First, Middle Initial): Doe, John J.
10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER: 123-45-6789
11. OTHER HEALTH INSURANCE COVERAGE
b. TYPE OF COVERAGE (Check all that apply)
c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE (Street, City, State, and ZIP Code) | d. INSURANCE IDENTIFICATION NUMBER | e. INSURANCE EFFECTIVE DATE (YYYYMMDD) | f. DRUG COVERAGE?
INSURANCE 1
INSURANCE 2
12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.
a. SIGNATURE: John J. Doe
b. DATE SIGNED (YYYYMMDD): 20090101
c. RELATIONSHIP TO PATIENT: Sponsor
13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY? [X] YES
HOW TO FILL OUT THE TRICARE/CHAMPUS FORM
DD FORM 2642 (BACK), APR 2007 — COPY 2 - PROCESSOR'S COPY

Specify reason for patient's visit/care.

Choose the currency to be reimbursed in.

Signature of patient or authorized person

Date Signed

Signer's relationship to the sponsor

Claims

Assisting Providers

Claims
Assisting Providers

Contact ISOS

Claims
Mailing Addresses

- ADSM:

WPS-Active Duty Overseas

P.O. Box 7968

Madison, WI 53707-7968

- ADFM/Ret/RetFM:

WPS-Foreign Claims

P.O. Box 7985

Madison, WI 53707-7985

Claims

Timely Filing Waivers

If it happens…

Claims
Timely Filing Waivers

- For claims not filed w/in the 1 year timely filing limit
- TMA may grant timely filing waiver for
  - Retroactive determinations
  - Administrative errors
  - Inability to communicate & mental incompetency
  - Provider change from non-participating to participating
  - OHI
  - Dual eligibility w/ Medicare
- Required for requesting a waiver
  - Written/typed request
  - Copy of original claim & supporting documentation
  - A copy of the EOB

Claims
Timely Filing Waivers

- Send requests to:

TRICARE Management Activity

Beneficiary & Provider Services (BPS)

16401 East Centretech Parkway

Aurora, CO 80011-9066

- For more information
  - TRICARE Operations Manual, “Claims Filing Deadline”, Chapter 8, Section 3

Follow Instructions in Letter

Claims

Appeals

Claims
Appeals

- 2 types of appeals:
  - Medical Necessity Appeals
    - *From a medical point of view, the care is appropriate, reasonable and adequate for the condition.*
  - Factual Appeals
    - *Other than medical necessity; i.e. whether or not covered under TRICARE policy/regulation*
- Must be mailed NLT 90 days from date on EOB or determination letter from WPS
- Required for submitting an appeal:
  - Signed written or typed request
  - Copy of EOB
  - Any documentation supporting the beneficiary's position

Claims
Appeals

- **Send appeal to:**

WPS TRICARE

ATTN: Appeals

P.O. Box 7992

Madison, WI 53707-7992

- **If the beneficiary is not satisfied with WPS' determination, they can appeal the decision to TMA**
  - See EOB and/or determination letter from WPS for instructions/guidelines for submitting appeals to TMA

Claims
Things to Remember

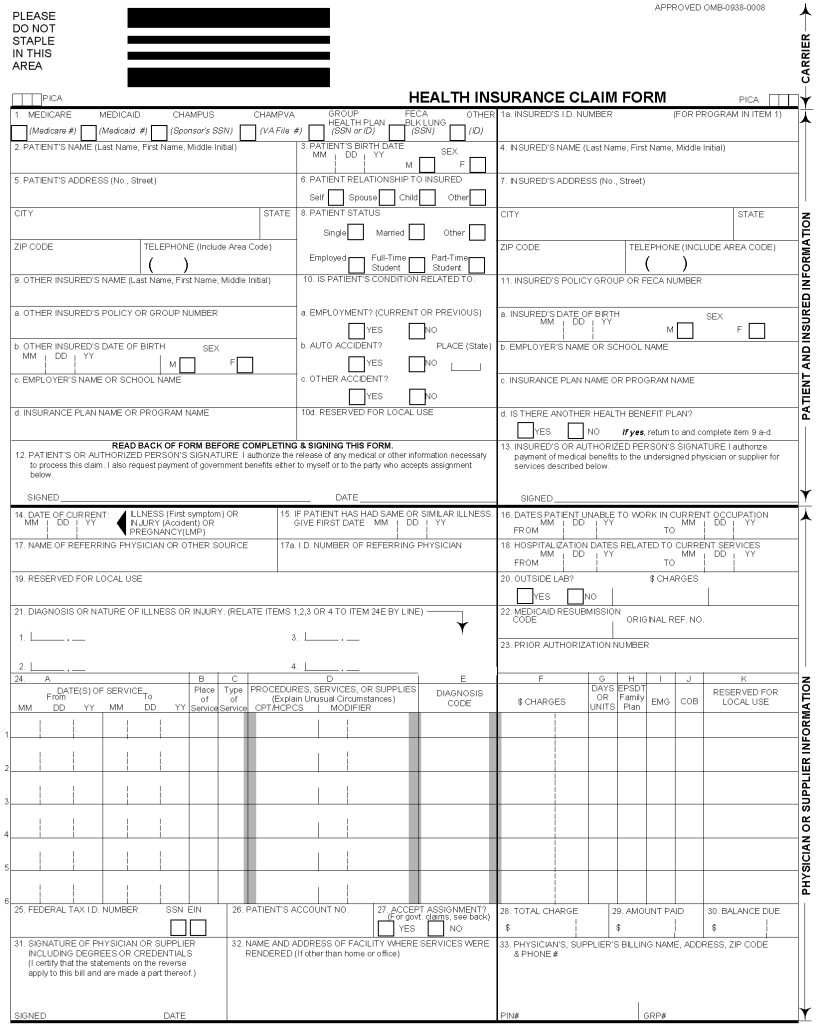
- Check DEERS to determine eligibility/appropriate claims address
- Checks for claims submitted by a POC will be sent to the POC
- Only POCs can fax claims to WPS
- Translation of supporting documents is not required
- Remind beneficiaries to keep copies of all documents
- Beneficiaries w/ OHI must submit a claim to their OHI first; then the OHI EOB (equivalent) needs to be sent w/ claim to TRICARE
- 21 days: Approx time WPS takes to process a claim
- *6-8 weeks: Approx time it takes a Beneficiary to receive correspondence/checks from WPS starting from the time the claim was initially sent in the mail to WPS*

Claims
Questions

Claims
Assisting Providers

- HCFA-1500 “Health Insurance Claim Form”
  - Most commonly used provider claim form
  - Can be found by doing a simple internet search
  - May also be found at your MTF’s Cashier’s Cage/Billing Office
- Required Supporting Documentation:
  - Itemized invoice, bill or statement
- Timely Filing Limit is same as beneficiary-submitted claims
- Electronic Funds Transfer (EFT)
  - EFT form only needs to be submitted once
  - Not available in the Philippines and South Korea
  - Provider responsible for all banking charges

Claims
Assisting Providers



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ . __ 3. _____ . __

2. _____ . __ 4. _____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Claims
Assisting Providers

HCFA 1500 – Key Points

- (12) Beneficiary must sign the HCFA-1500 or WPS will not process the claim.
- (27) In order for WPS to issue reimbursement check directly to provider, provider must accept assignment
- (31) A signature needs to be affixed to the HCFA 1500 or WPS may not process the claim
- (33) Check that the provider is using the address that they want to receive the reimbursement check

Claims
Assisting Providers